MMIS INSTITUTIONAL WEB PORTAL TRAINING

Laura Holzworth, Medical Services Division

NORTH
Dakota | Human Services
Be Legendary.™

ND Health Enterprise Web Portal Professional Claim Form Submission Instructions

Go to
https://**mmis**.nd.gov/**portals**/wps/**portal**/EnterpriseHome

➤ **Sign In - Provider**

North Dakota MMIS Web Portal

Home | Program ▸ | Member ▸ | Provider ▸ | Documentation ▸ | Directories ▸

Quick Links

- Enrollment
- ProviderManuals
- FAQ
- Billing Manuals
- Messages & Announcements

News

Governor's Task Force on Access to Affordable Health Insurance.

ND MMIS has established a scheduled maintenance window for calendar year 2019 from 9:00PM to 4:00AM Central Time on the 2nd Thursday of the month with the following exceptions: Jan 17, Apr 17, May 16, Nov 7, and Dec 19. During the maintenance window, the system may not be accessible.

Provider
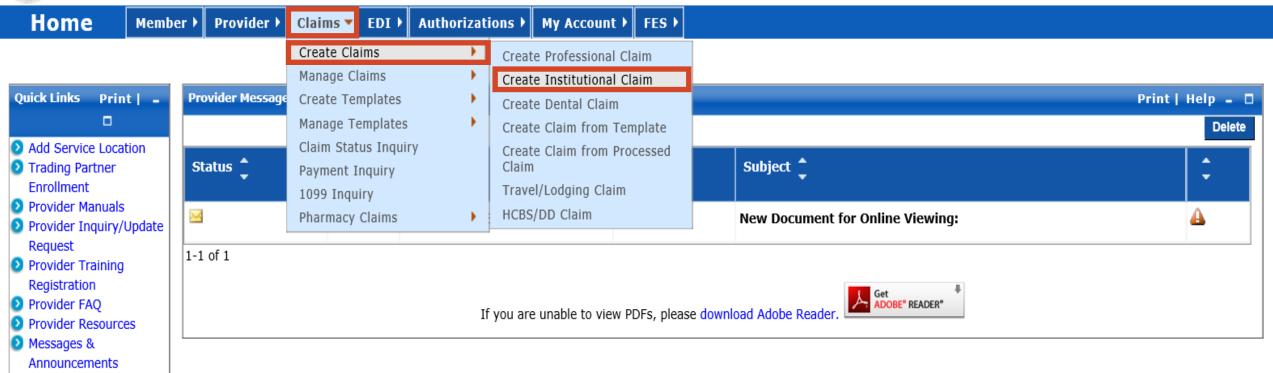
The Health Enterprise Portal is a state-of-the-art electronic health care administration system that gives patients, doctors, pharmacists and other users easy, secure and efficient access to health care information.

ProviderLogin

To access secure areas of the portal, please log in by entering your User ID and Password.

* User ID: [ ]

* Password: [ ]

Forgot User Name or Password ?

Login   Reset

➢ Provider Login
- ## USER ID and Password

> # **Submit a Claim**
> - Claims
> - Create Claims
> - Create Institutional Claim
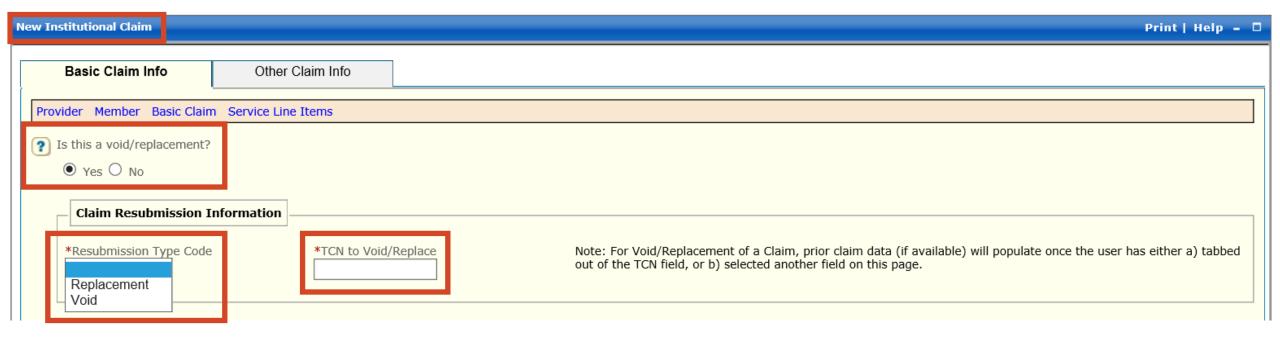
Basic Claim Info | Other Claim Info

Provider   Member   Basic Claim   Service Line Items

? Is this a void/replacement?

○ Yes ● No

Submitter Information
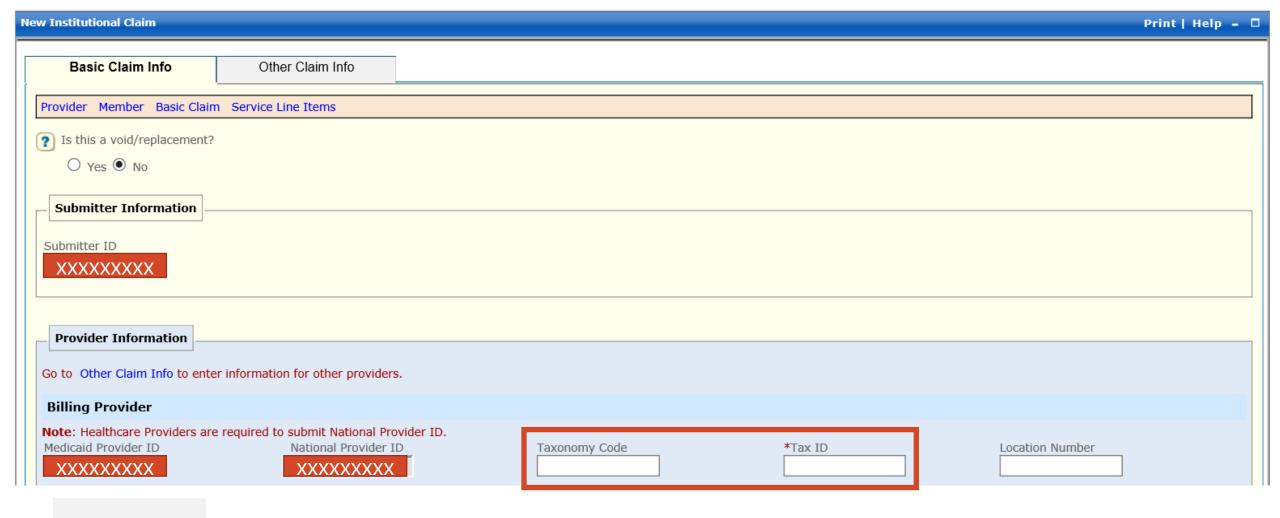
Submitter ID

XXXXXXXXX

> **New Institutional Claim**
> - Is this a void/replacement?
>   - ✓ Defaults to "No."
>   - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.
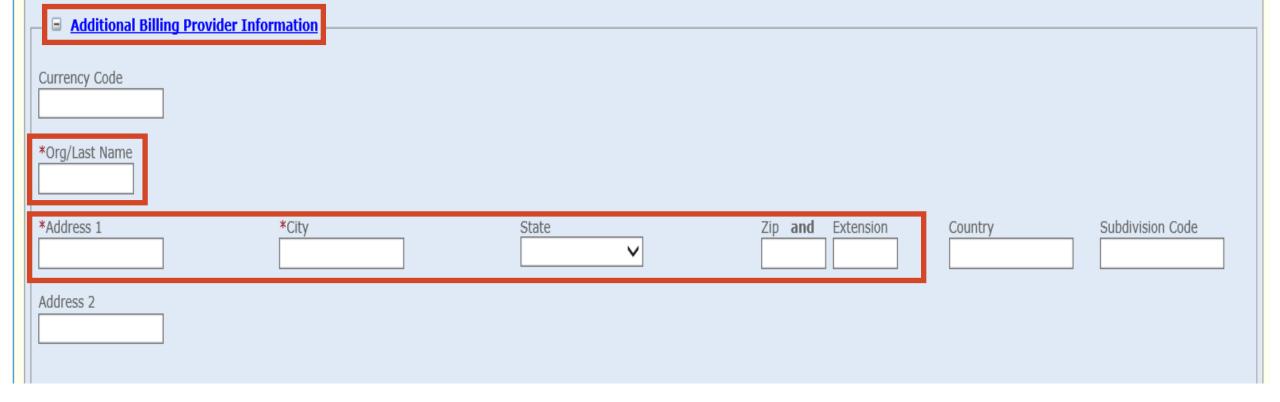
➢**New Institutional Claim**
- Is this a void/replacement?
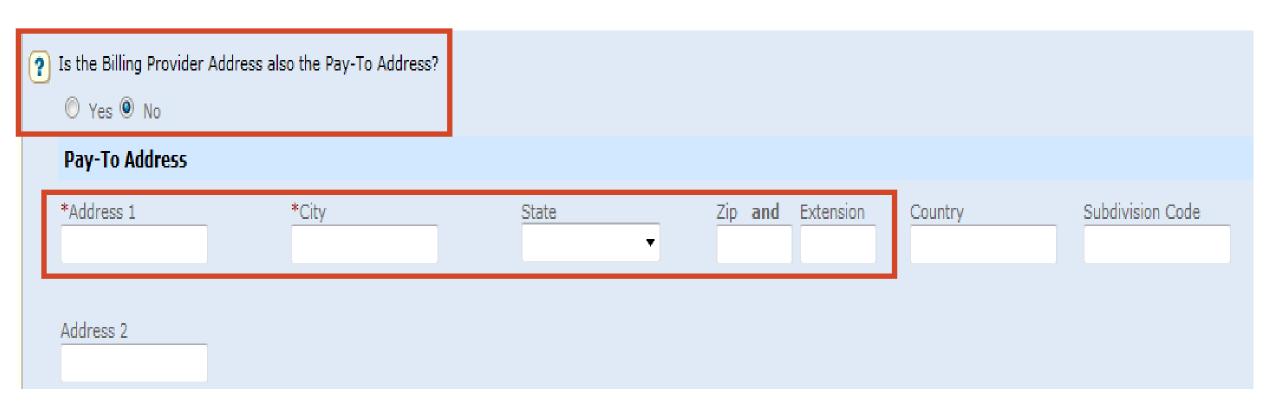 - ✓ Select "Yes" **only** if you are replacing or voiding a previously processed claim.
  - ✓ Resubmission Type Code – Replacement or Void
  - ✓ TCN to Void/Replace

➢**Enter** - Billing Provider Taxonomy Code

➢**Enter** - Billing Provider Tax ID or SSN Number
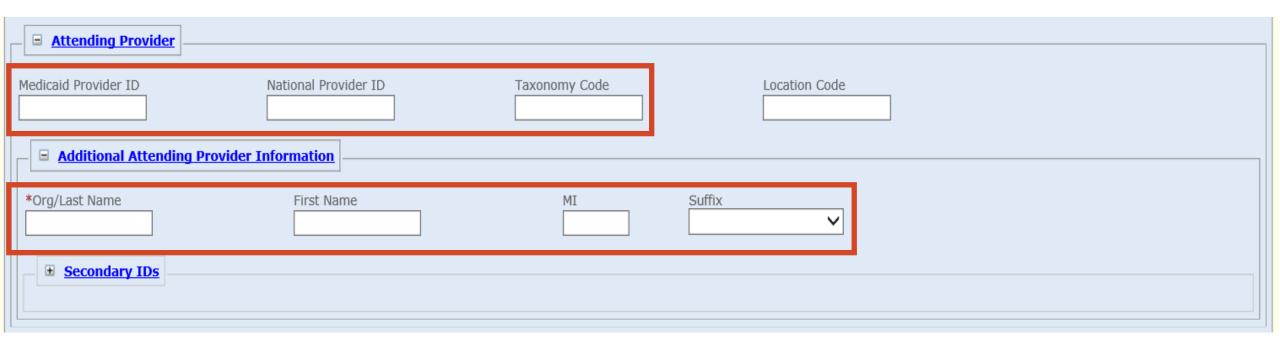
> **Additional Billing Provider Information**
> - **REQUIRED**
> - **Enter** – Org/Last Name, Address, City, State and Zip Code

➢ **Is the Billing Provider also the Pay-To Address?**
- • **Required -** Defaults to "Yes"
- • Pay-To Address is **different**, select "**No**"
  - ✓ Complete the Pay-To Address section with the Address, City, State and Zip Code

- ➢ **Attending Provider**
    - • **Required**
    - • Medicaid Provider ID, National Provider ID and Taxonomy

- ➢ **Additional Attending Provider Information**
    - • **Required**
    - • Org/Last Name, First Name, MI and Suffix

➢ **Member Information**

- **REQUIRED**
- **Enter -** Member's 9-digit ID number
- **Enter** - Member's Last Name
- **Enter -** Member's First Name
- **Enter -** Member's Date of Birth
  - ✓ Use format: MM/DD/YYYY
- **Enter -** Member's Gender
  - ✓ F = Female
  - ✓ M = Male
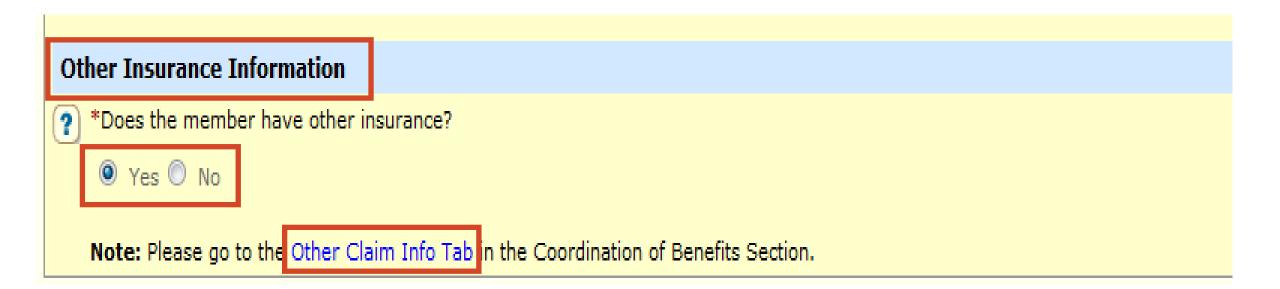
> **Member Address**
>   - **REQUIRED**
>   - **Enter** - Member's Address, City, State and Zip Code

Other Insurance Information

? *Does the member have other insurance?

○ Yes ● No
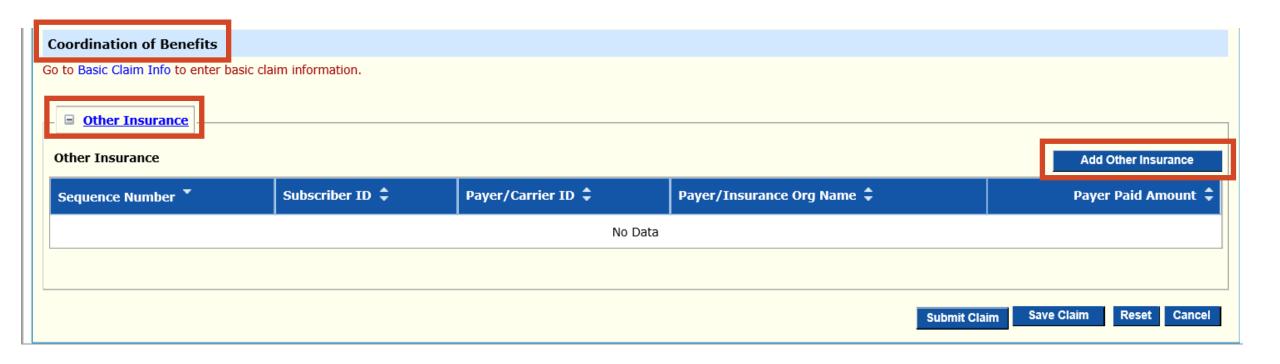
- **Does the member have other insurance?**
  - Yes or No

- **If "No" - member does not have other insurance – proceed to slide 24**

- **If "Yes" - member has other insurance– proceed to slide 15**

Other Insurance Information

? *Does the member have other insurance?

◉ Yes ○ No

Note: Please go to the Other Claim Info Tab in the Coordination of Benefits Section.
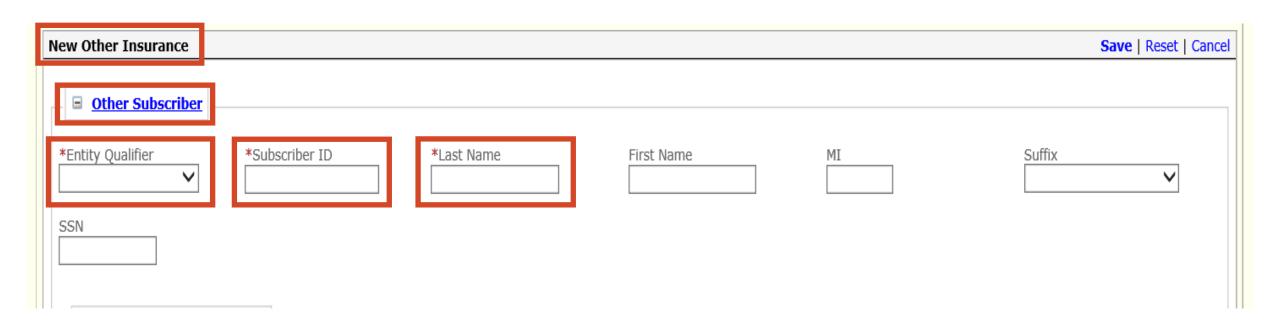
➢ **Other Insurance Information**
- **REQUIRED**
- Does the member have other insurance?
- Select "Yes"
- Click and complete the **Other Claim Info Tab** with the Other Insurance information

Coordination of Benefits
- **REQUIRED**
- Other Insurance
- Add Other Insurance

> **New Other Insurance**
> - **REQUIRED**
> - **Other Subscriber**
> - Entity Qualifier – Non-Person
> - Subscriber ID – Member's Primary Insurance ID number
> - Last Name – Member's Last Name
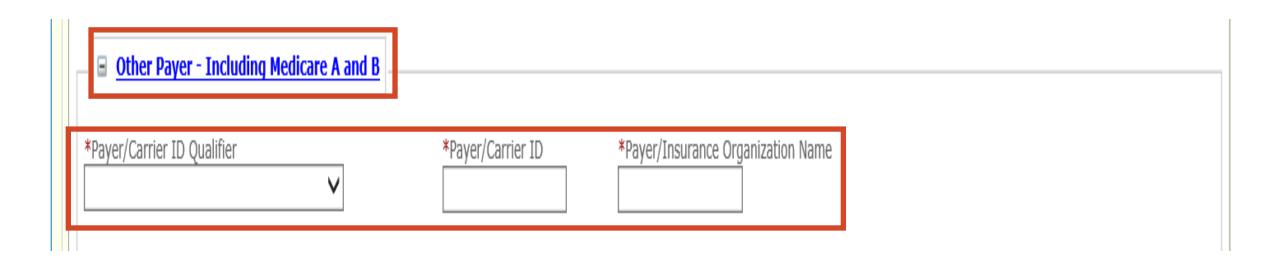
> ## Other Insurance Coverage
> - **REQUIRED**
> - Release of Information Code
> - Select appropriate value
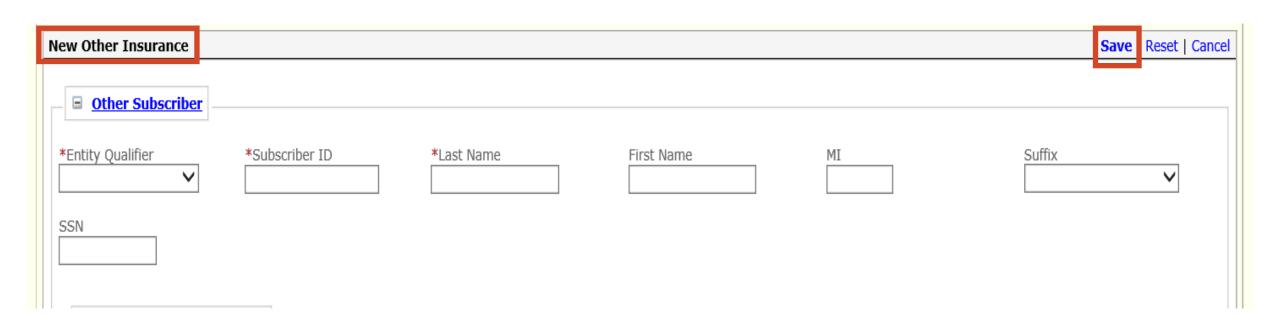
Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes

Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim

Other Payer – Including Medicare A and B

- Payer/Carrier ID Qualifier – Select Payer Identification
- Payer/Carrier ID – Insurance Payer/Carrier ID number
- Payer/Insurance Organization Name – Insurance Name

> **New Other Insurance**
>   - **REQUIRED**
>   - Scroll to the top of **New Other Insurance** section
> **SAVE**

- **Other Insurance**

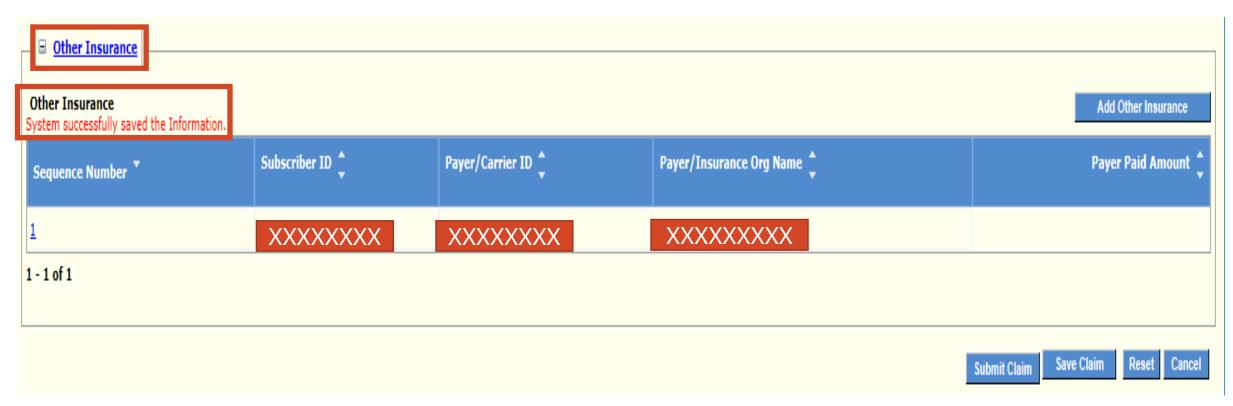| Sequence Number	Subscriber ID	Payer/Carrier ID	Payer/Insurance Org Name	Payer Paid Amount
1	XXXXXXXX	XXXXXXXX	XXXXXXXXX	

Other Insurance
System successfully saved the Information.

Add Other Insurance

1 - 1 of 1

Submit Claim   Save Claim   Reset   Cancel

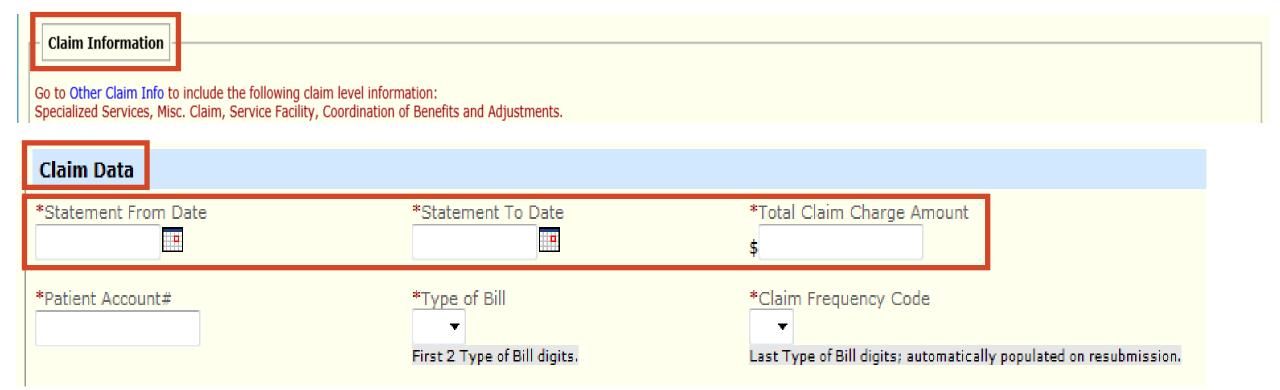➤ **System successfully saved the Information**
- Verify the Insurance was added
- Sequence Number
- Subscriber ID
- Payer/Carrier ID
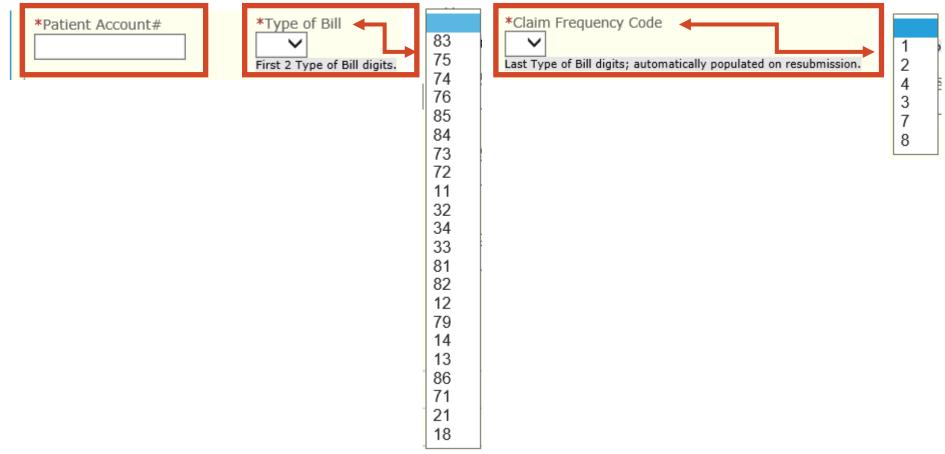- Payer/Insurance Org Name

➢ **Save Claim**

➤ **Navigate** to the **Basic Claim Info Tab**

Claim Information

Go to Other Claim Info to include the following claim level information:
Specialized Services, Misc. Claim, Service Facility, Coordination of Benefits and Adjustments.

Claim Data

*Statement From Date

*Statement To Date

*Total Claim Charge Amount
$

*Patient Account#

*Type of Bill

First 2 Type of Bill digits.

*Claim Frequency Code

Last Type of Bill digits; automatically populated on resubmission.

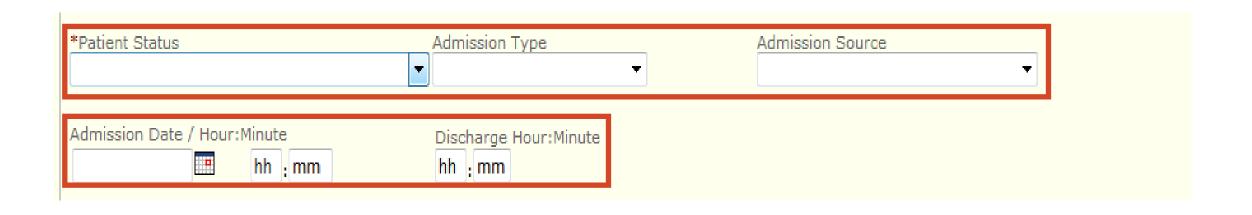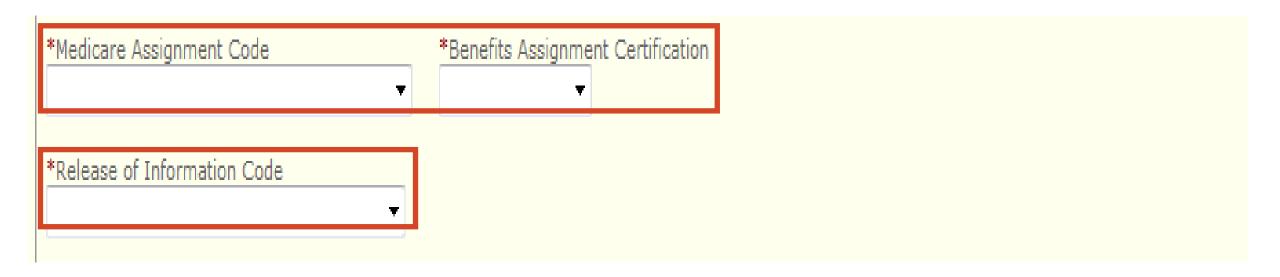➢ **Claim Data Information**
➢ **Claim Data**
  • **REQUIRED – regardless if there is a red asterisk by the field**
  • Statement From Date and Statement To Date
    ✓ Use format: MM/DD/YYYY
  • Total Claim Charge Amount
    ✓ Enter the total amount billed
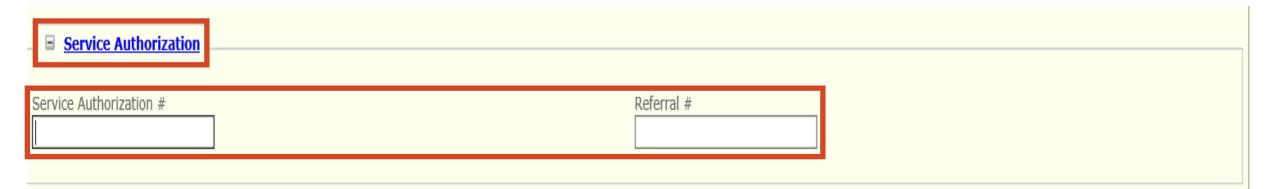
24

> **Claim Data Information**
> - Patient Account # - Enter the internal patient account number will print on remittance advice
> - Type of Bill – First 2 digits of the Type of Bill
> - Claim Frequency Code – last digit of the Type of Bill

➢ Claim Data Information

- **REQUIRED – regardless if there is a red asterisk by the field**
- Patient Status
- Admission Type
- Admission Source
- Admission Date/Hour:Minute
  - ✓ Use date format: MM/DD/YYYY. Use military format: HH:MM
- SITUATIONAL – Discharge Hour:Minute
  - ✓ If patient is other than "Still a Patient" you must enter the hour:minute the member was discharged. Use military format: HH:MM
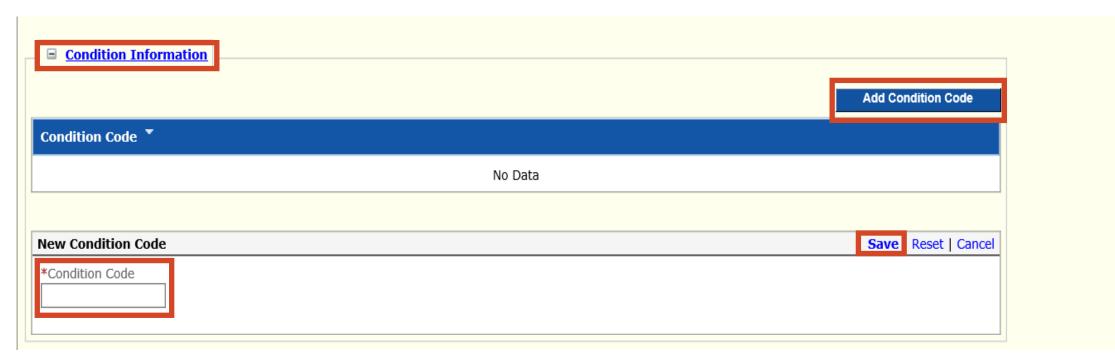
> # **Claim Data Information**
> - **REQUIRED**
> - Medicare Assignment Code
> - Benefits Assignment Certification
> - Release of Information Code
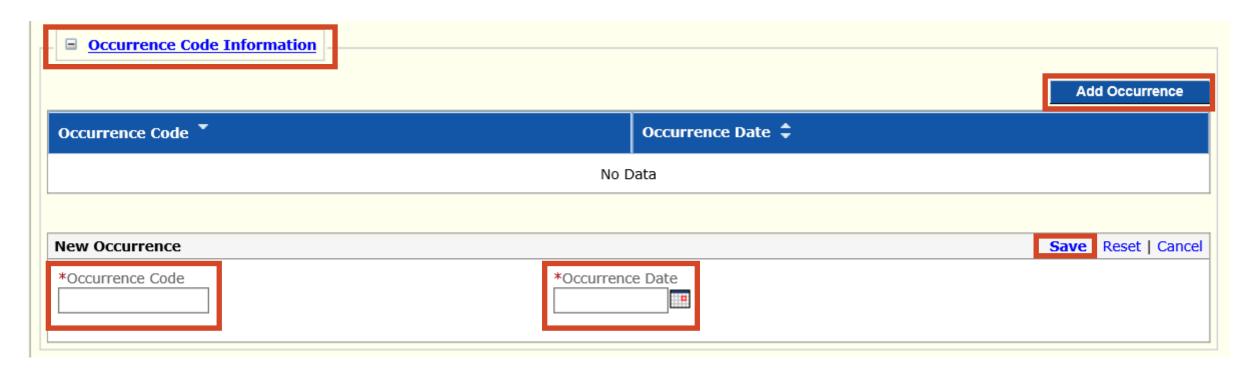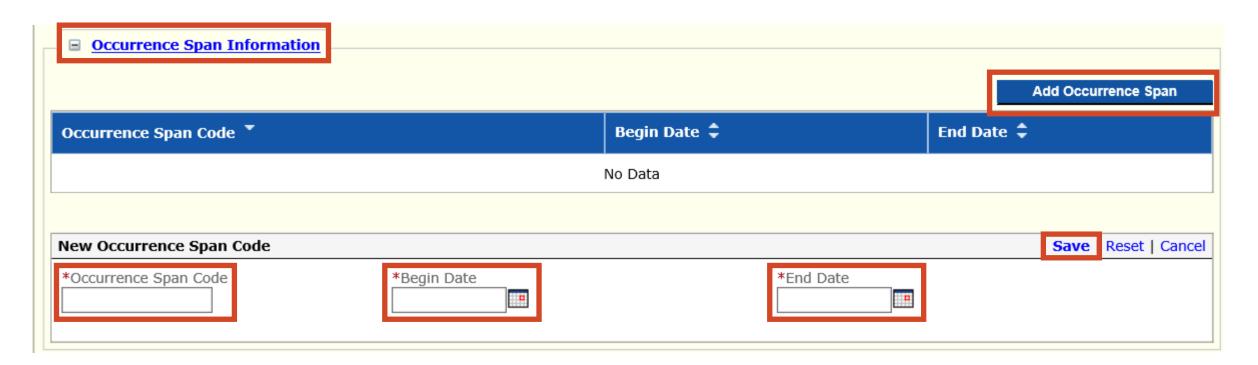
➢ **Service Authorization**
- **REQUIRED – if applicable**
- Service Authorization Number
- Referral Number

➢ Condition Information
➢ Add Condition Code
- **REQUIRED – if applicable**
- Condition Code
- **Save**

➢ **Occurrence Code Information**

➢ **Add Occurrence**
- **Required – if applicable**
- Occurrence Code
- Occurrence Date
- **Save**
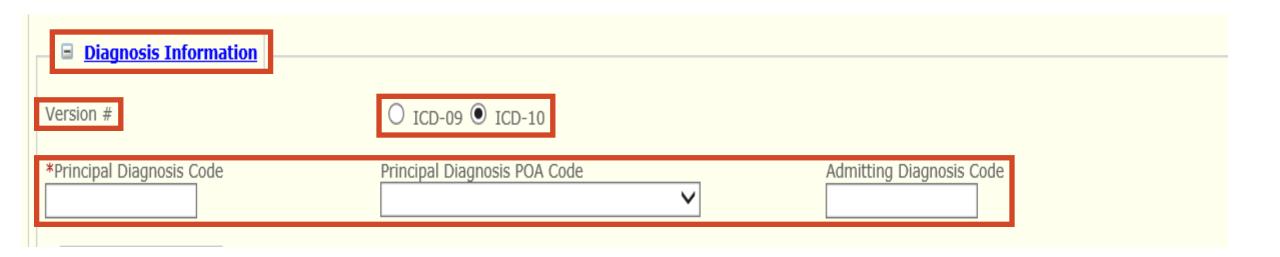
➢ **Occurrence Span Information**

➢ **Add Occurrence Span**
- **Required – if applicable**
- Occurrence Span Code
- Begin Date
- End Date
- **Save**
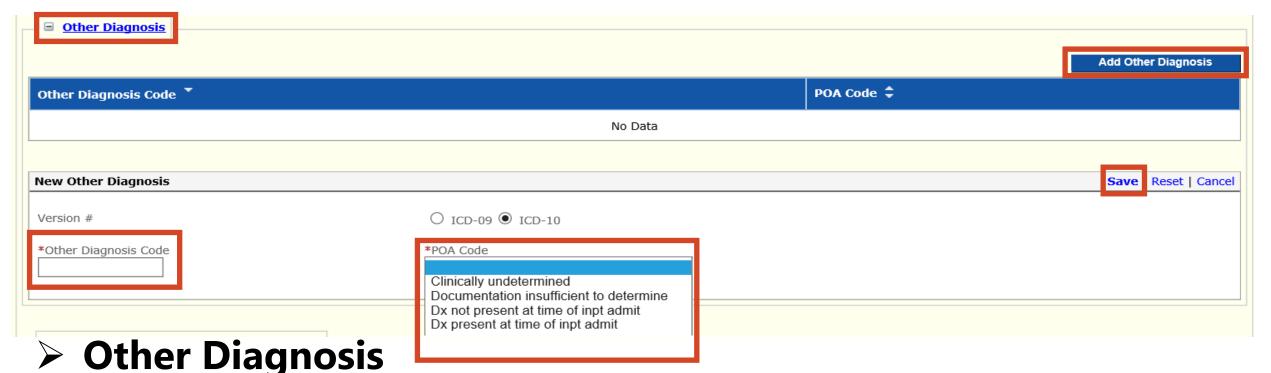
> **Value Information**
> **Add Value**
> * **REQUIRED – if applicable**
> * Value Code - 80 = Covered Days
> * Value Amount - Value Amount should be entered as a dollar amount
>   * ✓ Example: 30 days = 30.00
> * **Save**
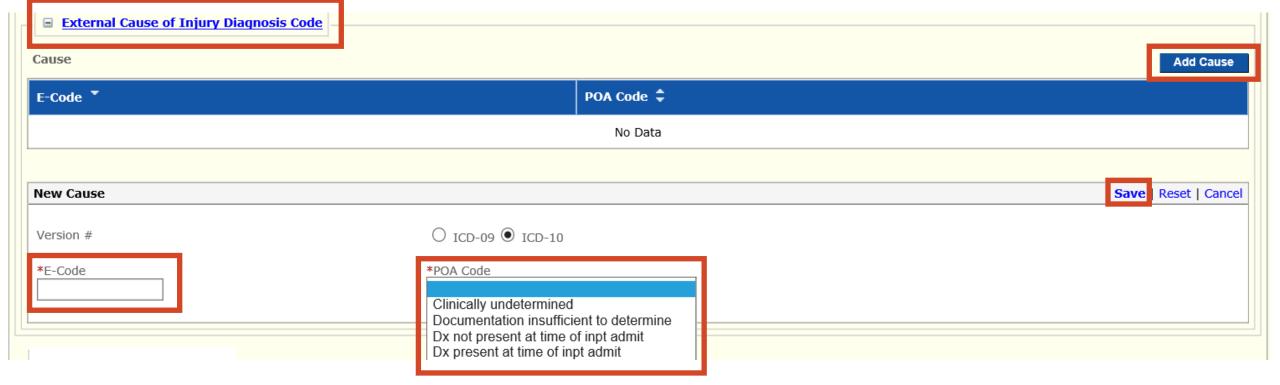
> # Diagnosis Information
> - **REQUIRED**
> - **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
> - **Principal Diagnosis Code**
>   - ✓ Enter the diagnosis code for the member's primary diagnosis
> - **Principal Diagnosis POA Code – if applicable**
> - **Admitting Diagnosis Code – if applicable**

> # Other Diagnosis
> # Add Other Diagnosis
> - **REQUIRED – if applicable**
> - **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
> - **Other Diagnosis Code - Additional Diagnosis Codes**
>   - ✓ Enter the diagnosis code for the member's additional diagnosis's
> - **POA Code - if not applicable – select Clinically undetermined**
> - **Save**
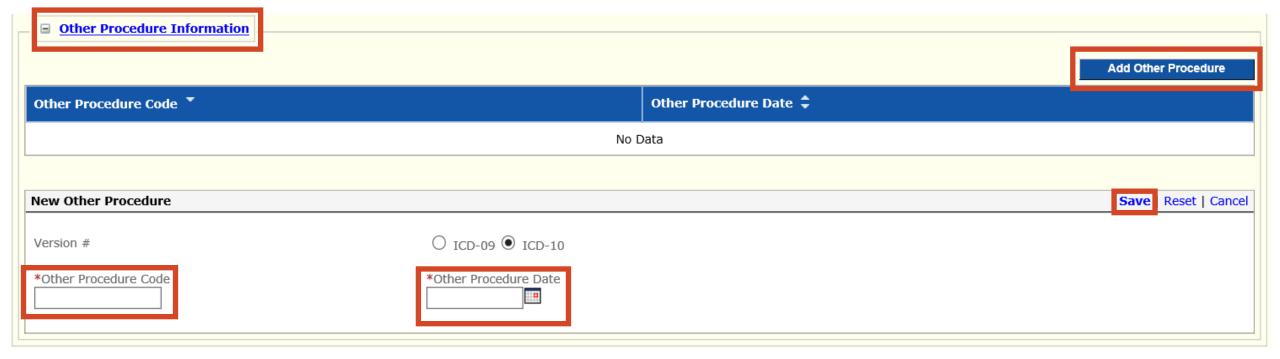
External Cause of Injury Diagnosis Code
Add Cause
- **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
- Enter E-Code
- POA Code
- **Save**

> **Procedure Information**
>   - **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
>   - Principal Procedure Code
>   - Procedure Date
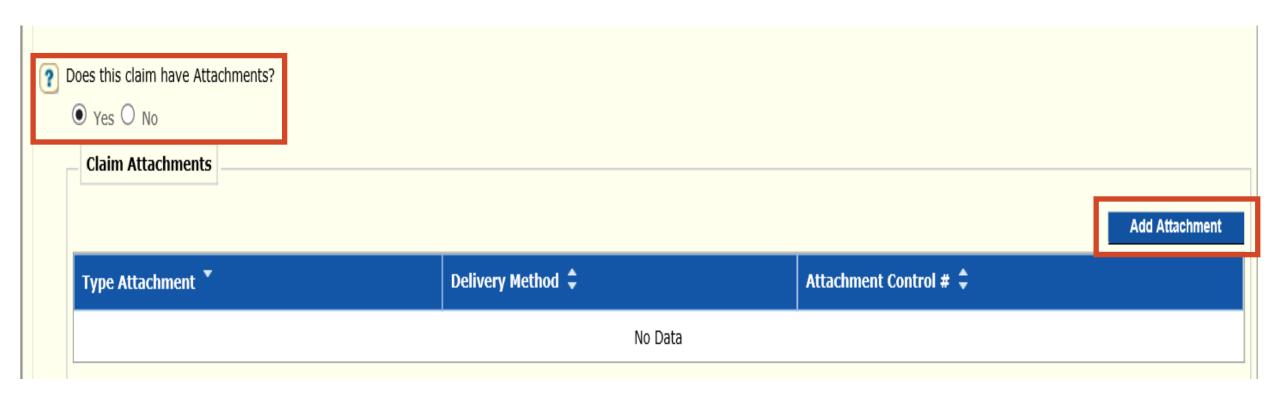
> **Other Procedure Information**
> **Add Other Procedure**
> - **Version #** - Defaults to ICD-10 – Select appropriate version based on date of service
> - Other Procedure Code
> - Other Procedure Date
> - **Save**
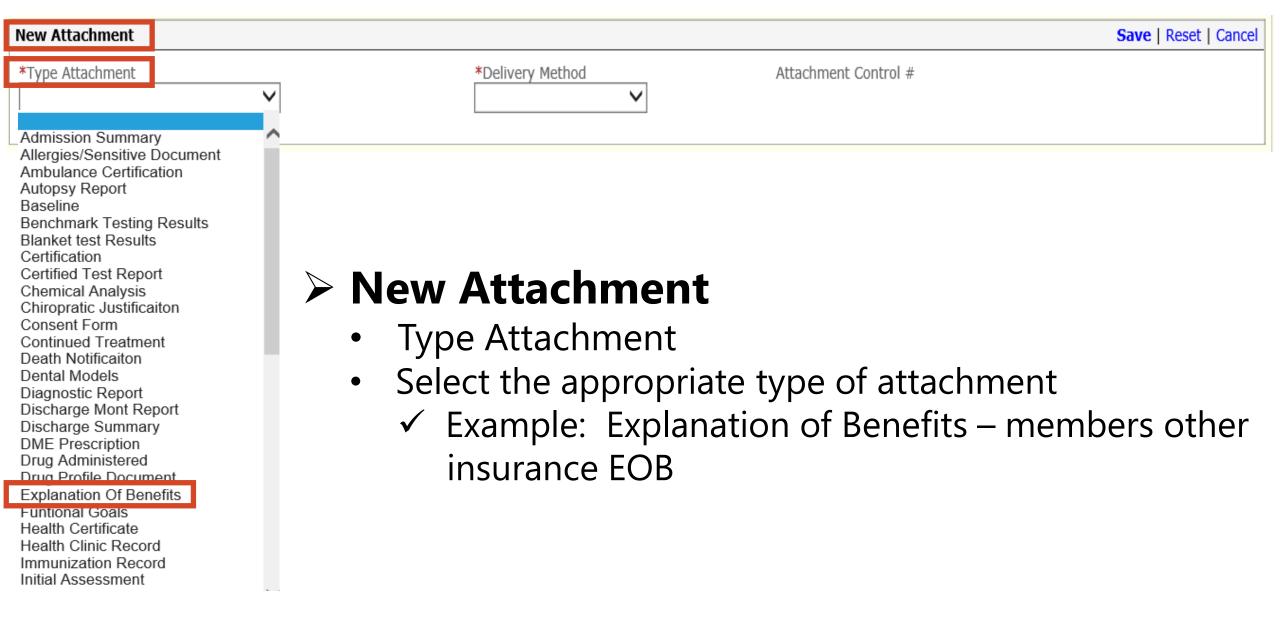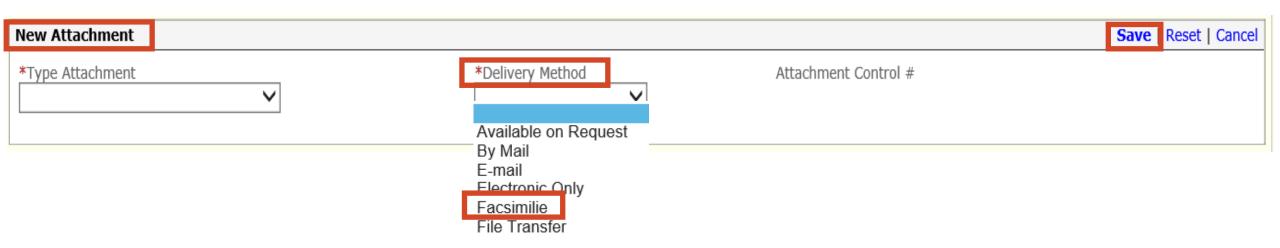
➤ **Billing Note**
- Add any pertinent information
  - ✓ Example Note: Proving the One-Year Timely Filing Limit Policy Remittance Advice (RA) Date and TCN Number

> **Does this claim have Attachments?**
> - Yes
>
> **Add Attachment**
> - Add Attachment

New Attachment

*Type Attachment	*Delivery Method	Attachment Control #

Admission Summary
Allergies/Sensitive Document
Ambulance Certification
Autopsy Report
Baseline
Benchmark Testing Results
Blanket test Results
Certification
Certified Test Report
Chemical Analysis
Chiropratic Justificaiton
Consent Form
Continued Treatment
Death Notificaiton
Dental Models
Diagnostic Report
Discharge Mont Report
Discharge Summary
DME Prescription
Drug Administered
Drug Profile Document
Explanation Of Benefits
Funtional Goals
Health Certificate
Health Clinic Record
Immunization Record
Initial Assessment

➢ **New Attachment**
- Type Attachment
- Select the appropriate type of attachment
  - ✓ Example: Explanation of Benefits – members other insurance EOB

> # New Attachment
>   - ## Delivery Method
>   - Select the Facsimilie – fax in to the appropriate number
>   - Faxed documentation needs to have a SFN177 cover form
>   - SFN 177 link: https://www.nd.gov/eforms/Doc/sfn00177.pdf
>
> # SAVE
>
> # Claim Submitted Confirmation Page may be substituted for the SFN 177

MMIS ATTACHMENT COVER SHEET – SFN 177

MMIS ATTACHMENT COVER SHEET
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 177 (6-2015)

Clear Fields

Complete this form and include it as the cover sheet for all attachments or additional documentation being submitted to the North Dakota Department of Human Services Medicaid.

Provider NPI or Medicaid Number

Member Medicaid Number

Corresponding Record Number

Type of Attachment (select only one)

☐ Claim

Transaction Control Number (TCN)	Fax To: 701-328-0374

☐ Service Authorization (SA)

Service Authorization (SA) Number	Fax To: 701-328-1544

☐ Referral

Referral Number	Fax To: 701-328-1544

☐ Other

Description	Fax To: 701-328-1544

Mail to:

North Dakota Department of Human Services
MMIS Attachments
600 East Blvd Ave.
Bismarck, ND 58505

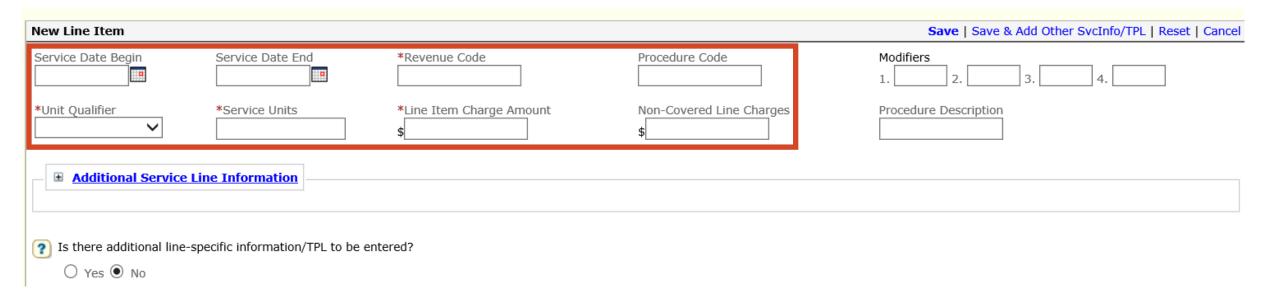Telephone Number: 1-877-328-7098

➢ **Required**
- Provider NPI or Medicaid Number
- Member Medicaid Number

- **Type of Attachment** – **Select only one**
  - ✓ Claim - Transaction Control Number (TCN)
  - ✓ Service Authorization (SA) – SA Number
  - ✓ Referral – Referral Number
  - ✓ Other – Description
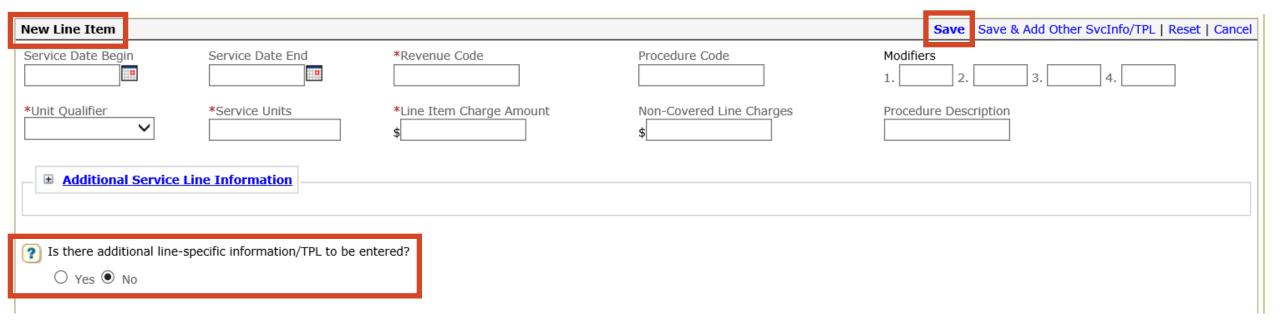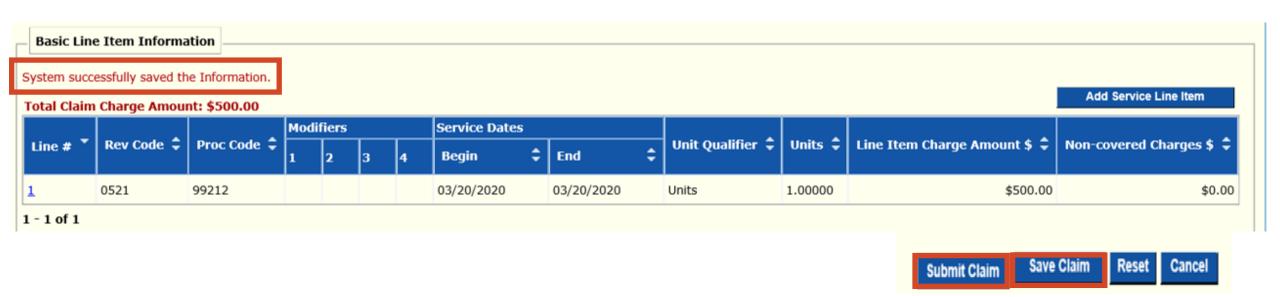 - ✓ Fax to the appropriate phone number

➤ New Line Item

- Service Date Begin – Use Format: MM/DD/YYYY
- Service Date End – Use format: MM/DD/YYYY
- Revenue Code
- Procedure Code – if applicable
- Unit Qualifier
- Service Units
- Line Item Charge Amount
- Non-Covered Line Charges – if applicable

> **Is there Additional line-specific information/TPL to be entered?**
> - **No** – member **does not** have other insurance
> - **Yes** – member **does** have other insurance – proceed to slide number **47**
> - **Save** – **New Line Item**

> **Is there Additional line-specific information/TPL to be entered?**
> - **No** – member does not have other insurance
> - **Save** – **New Line Item**
> - **Verify System successfully saved the Information**

> **SAVE CLAIM**
> **SUBMIT CLAIM**

TCN: [redacted]

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

Claim Information

TCN: [redacted]

Date of Service: 03/20/2020 – 03/20/2020

Provider #: [redacted]

Member ID: [redacted]

Claim Status: C - To Be Dnd

Total Charge: $500.00

*To Be Paid Amount: $0.00

*Co-Payment: $0.00

*Total Recipient Liability: $0.00

Submission Date/Time: 08/14/2020 2:49:11 PM CDT

*This may not be the actual amount. Please refer to your remittance advice for detailed payment information.
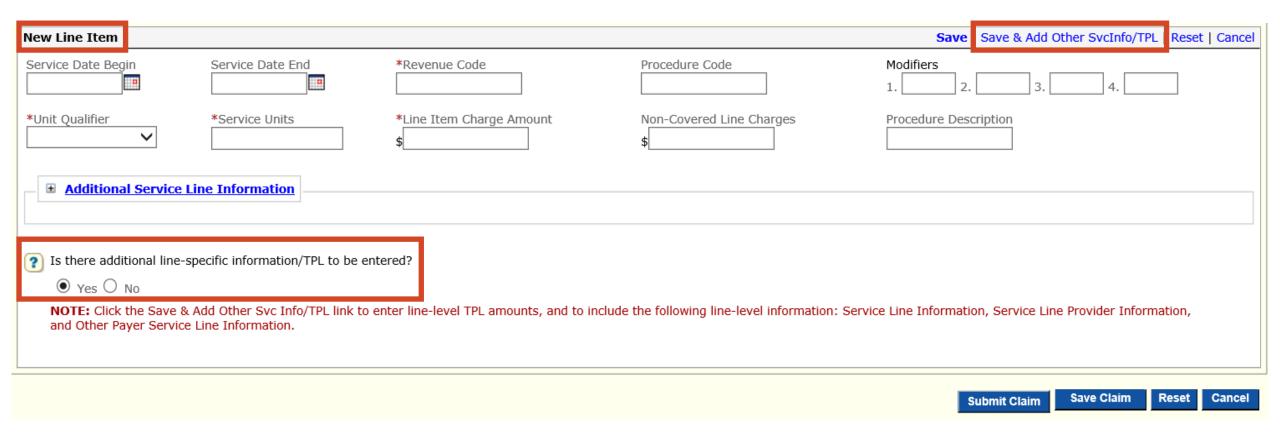
Adjustment Reason Codes

Line #	Adjustment Reason Code	Description
0	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
0	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

1 - 2 of 2

Remark Codes

Line #	Remark Code	Description
0	N253	Missing/incomplete/invalid attending provider primary identifier.

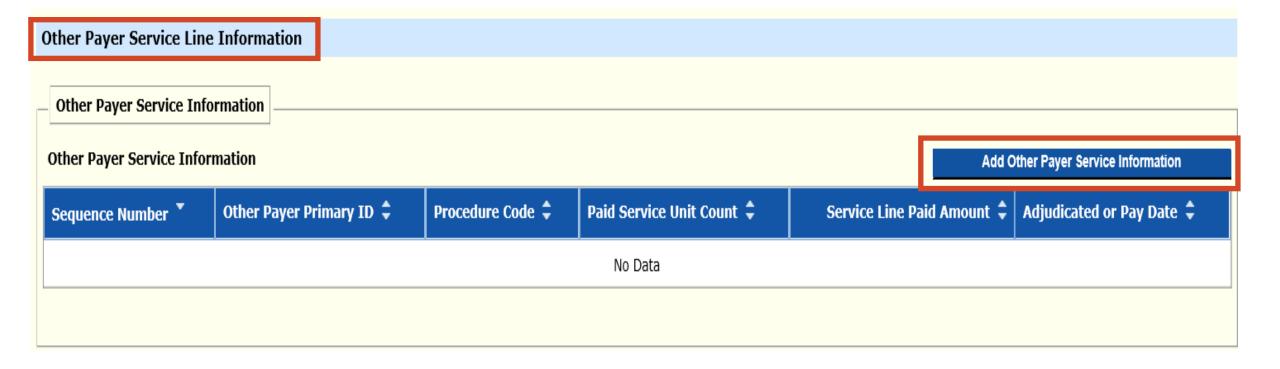➢ **Print and Save for your records**

46

> **Is there Additional line-specific information/TPL to be entered?**
>   - **Yes** – Member has Other Insurance
>   - **Save & Add Other Svc Info/TPL**

New Institutional Claim

System successfully saved the Information.

Ln #:1

Submit Claim | Save & Return to Basic Service Line Item | Save Claim | Reset | Cancel
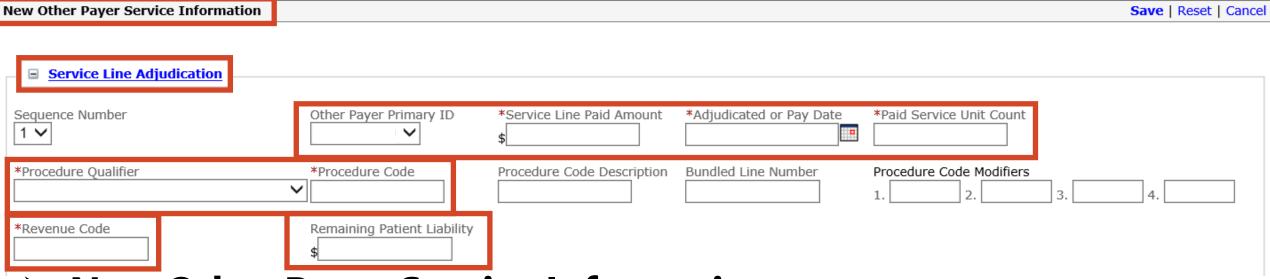
> ## **New Institutional Claim**
> - System successfully saved the Information
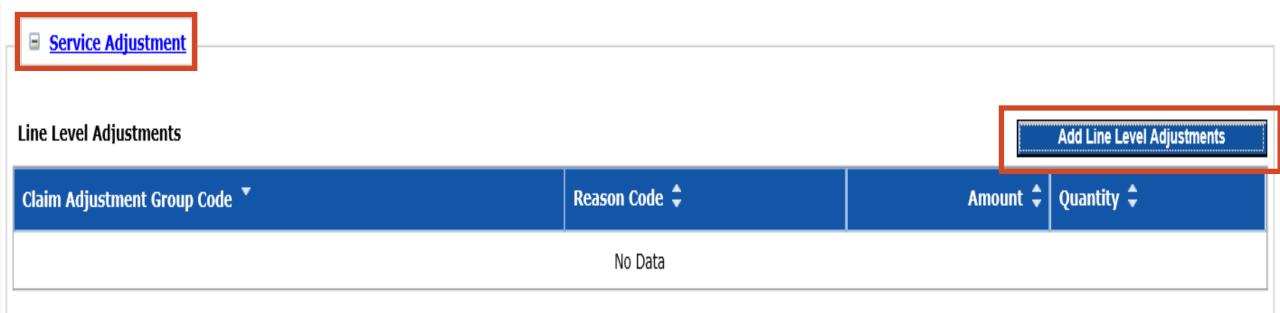>   - ✓ **Line # 1**
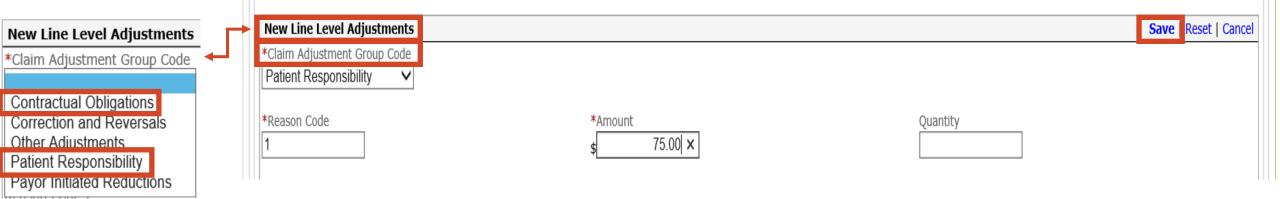
> **Other Payer Service Line Information**
> - Add Other Payer Service Information

> **New Other Payer Service Information**
> **Service Line Adjudication**
>> ✓ **REQUIRED**
>> ✓ Other Payer Primary ID
>> ✓ Service Line Paid Amount
>> ✓ Adjudicated or Pay Date
>> ✓ Paid Service unit Count
>> ✓ Procedure Qualifier - ABC
>> ✓ Procedure Code
>> ✓ Revenue Code
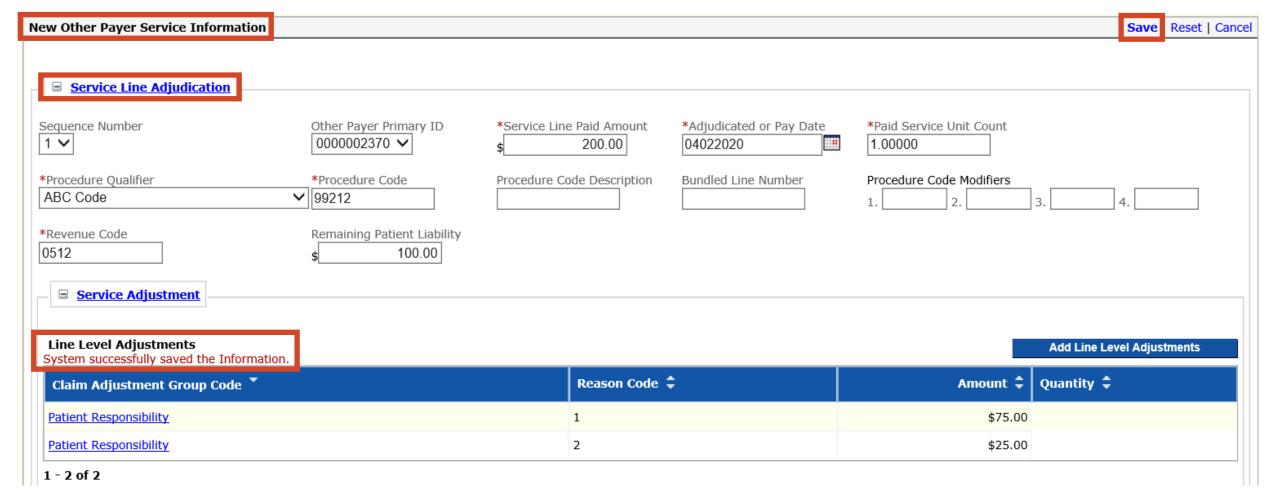>> ✓ Remaining Patient Liability

- **Service Adjustment**
- **Add Line Level Adjustments**
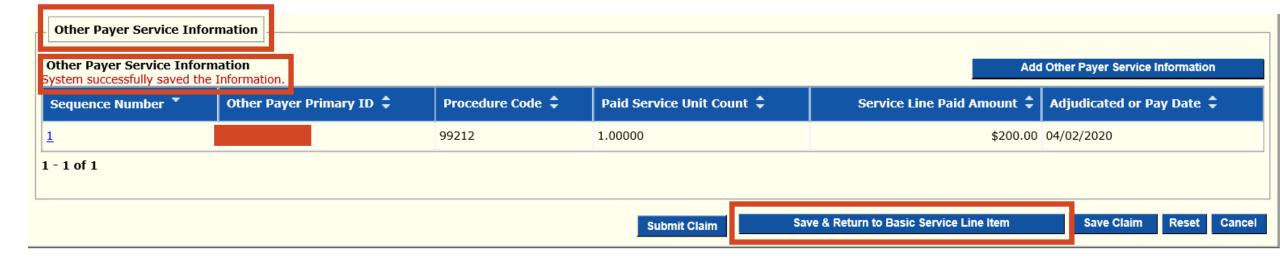
➤ **New Line Level Adjustments**
- Claim Adjustment Group Code – **Patient Responsibility** or **Contractual Obligation**
   - ✓ Only 1 Claim Adjustment Group Code may be selected at a time

- Reason Code and Amount - **(Do Not enter PR or CO in front of Reason Code)**
   - ✓ **Patient Responsibility –** add reason code and amount
   - ✓ **Save**
   - ✓ **Contractual Obligations –** add reason code and amount
   - ✓ **Save**
- **Add new Line Level Adjustments for each Reason Codes per detail line**

> # **New Other Payer Service Information**
> - Additional Adjustments - Add Line Level Adjustments – if applicable
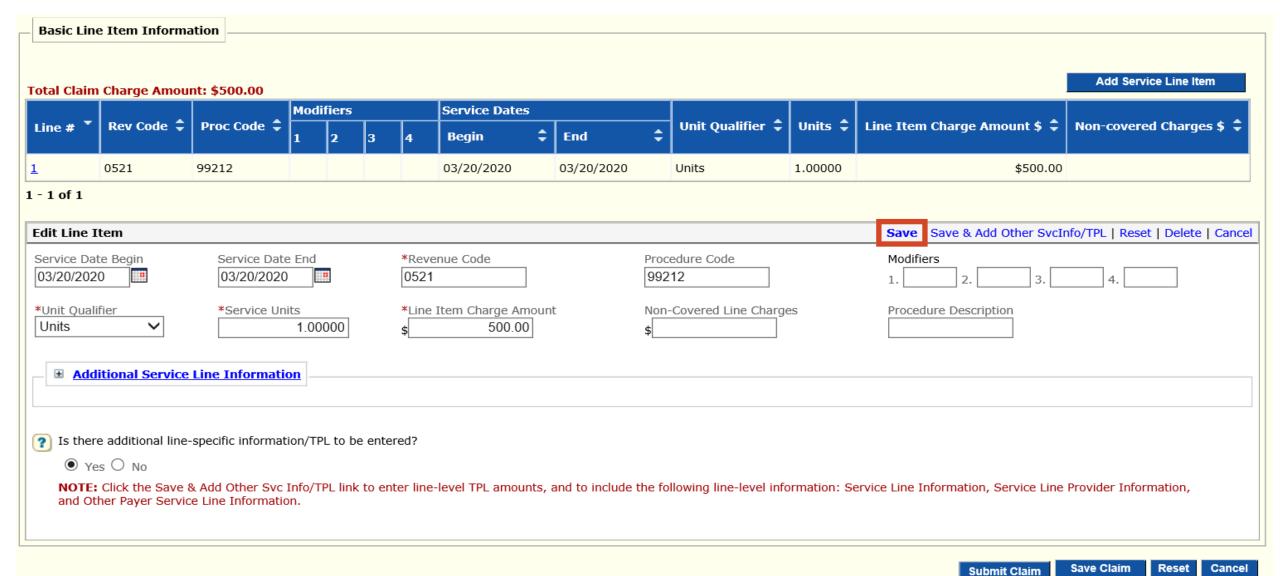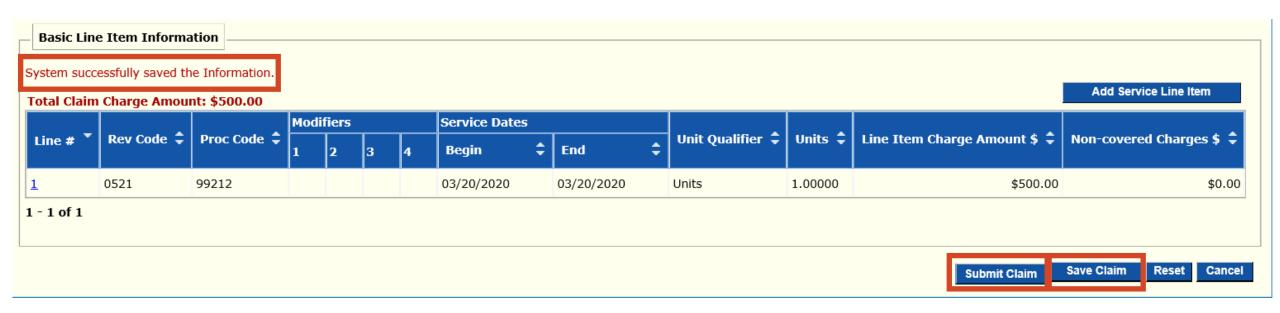> - Verify Line Level Adjustments saved
> - **Save – New Other Payer Service Information**

Other Payer Service Information
System successfully saved the Information.

Add Other Payer Service Information

Sequence Number	Other Payer Primary ID	Procedure Code	Paid Service Unit Count	Service Line Paid Amount	Adjudicated or Pay Date
1	▆▆▆▆▆	99212	1.00000	$200.00	04/02/2020

1 - 1 of 1

Submit Claim   Save & Return to Basic Service Line Item   Save Claim   Reset   Cancel

➢ **If the member has 2 Insurance Policies**
   • **Add Other Payer Service Information**
      ✓ Complete a 2nd Sequence Number – Repeat slides 49 – 53
      ✓ Primary is Sequence Number #1
      ✓ Secondary is Sequence Number #2

➢ **If the member has 1 insurance**
➢ **Save & Return to Basic Service Line Item**

> **Save Line**

- ➢ **System successfully saved the Information**

- ➢ **Save Claim – Needs to be done before submitting the claim**
  - In order to re-submit the claim from a processed claim if need be

- ➢ **Submit Claim**

TCN: ▨

Your claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required.

Claim Information

TCN: ▨

Date of Service: 03/20/2020 - 03/20/2020

Provider #: ▨

Member ID: ▨

Claim Status: C - To Be Dnd

Total Charge: $500.00

*To Be Paid Amount: $0.00

*Co-Payment: $0.00

*Total Recipient Liability: $0.00

Submission Date/Time: 08/14/2020 2:49:11 PM CDT

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0	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

1 - 2 of 2

Remark Codes

Line #	Remark Code	Description
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